OREGON OFFICE of RURAL HEALTH

Oregon Health Authority

Race and Ethnicity

How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry?**

_____

Which of the following describes your **racial or ethnic identity?** Please check **ALL** that apply.

American Indian or Alaska Native

- ☐ American Indian
- ☐ Alaska Native
- ☐ Canadian Inuit, Metis, or First Nation
- ☐ Indigenous Mexican, Central American, or South American

Hispanic or Latino/a/x

- ☐ Central American
- ☐ Mexican
- ☐ South American
- ☐ Other Hispanic or Latino/a/x

Asian

- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino/a
- ☐ Hmong
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ South Asian
- ☐ Vietnamese
- ☐ Other Asian

Native Hawaiian or Pacific Islander

- ☐ Guamanian or Chamorro
- ☐ Micronesian
- ☐ Native Hawaiian
- ☐ Samoan
- ☐ Tongan
- ☐ Other Pacific Islander

Black or African American

- ☐ African American
- ☐ African (Black)
- ☐ Caribbean (Black)
- ☐ Other Black

Middle Eastern/Northern African

- ☐ Northern African
- ☐ Middle Eastern

White

- ☐ Eastern European
- ☐ Slavic
- ☐ Western European
- ☐ Other White

Other Categories

- ☐ Other (please list) _____
- ☐ Don't know/Unknown
- ☐ Don't want to answer/Decline

IMPORTANT

Providers may apply a total of 3 times to Oregon Health Care Provider Loan Repayment. Handwritten applications will not be reviewed. Applicants must use the fillable PDF, or otherwise type out their application.

Applicants are required to submit their application themselves. Clinic staff, or other representatives, cannot submit applications on behalf of an applicant.

Providers working in emergency care, urgent care, or inpatient settings are ineligible for Oregon Health Care Provider Loan Repayment.

If awarded though Oregon Health Care Provider Loan Repayment providers will be required to complete their service obligation at an approved practice site in Oregon. In the event of a practice failure or other extenuating circumstance an awardee needing to switch practice sites will be required to seek prior approval and submit documentation for the needed change (OAR 409-036-0090).

While medical providers in eligible disciplines may apply for more than one Loan Repayment Program at a time, if offered an award by more than one program, only one award may be accepted. Once a Loan Repayment program contract is in place, awardees are unable to switch programs, and must complete their service obligation before applying to other Loan Repayment programs. Examples of Loan Repayment programs include, but are not limited to, Oregon Partnership State Loan Repayment Program (SLRP), National Health Service Corps (NHSC), Oregon Health Care Provider Loan Repayment, NURSE Corps, NHSC Scholars, and/or other State, Federal, or local Loan Repayment Programs offering funds in exchange for a service obligation.

Oregon Health Care Provider Loan Repayment
(A Component of Oregon's Health Care Provider Incentive Program)

The Healthcare Provider Incentive Program's loan repayment subsidy supports Oregon's health system transformation efforts to ensure an adequate supply of primary care providers providing medical, dental, and behavioral health care in outpatient settings in underserved areas of Oregon.

Eligible Licensed Provider Types

- MDs, DO, & NDs (family medicine, general practice, internal medicine, geriatrics, pediatrics or OB/GYN);
- NPs (family medicine, women's health care, geriatrics; pediatrics, psychiatric mental health, family practice or nurse midwifery);
- PAs (family medicine, general practice, general internal medicine, geriatrics, pediatrics or OB/GYN);
- DMDs & DDS (general or pediatric);
- Expanded Practice Dental Hygienists;
- Psychiatrists (general, child/adolescent or geriatric);
- Pharmacists;
- Clinical Psychologists;
- Mental Health Providers (LCSWs, LPCs, LMFTs)

Qualifying Practice Sites

For loan repayment, a provider must serve at a site that:

- Is located in a Health Professional Shortage Area (HPSA), or has a Facility HSPA; **AND**
- Is serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county; **AND**
- Has a Site Application on file with the Oregon Office of Rural Health that is no more than 1 year old.

Award Information

In exchange for qualifying service, providers may receive funds to repay qualifying graduate-level, (or for expanded practice dental hygienists, undergraduate-level) loan debt. Awards will be calculated based on the balance owed on qualifying loans upon program entry.

Full time service providers must commit to a 3 year minimum service obligation in exchange for a tax free award of 50% of their qualifying loan debt balance, up to $35,000 per obligation year. Part time service providers must commit to a 3 year minimum service obligation in exchange for a tax free award of 25% of their qualifying loan debt balance, up to $25,000 per obligation year.

Failure to complete the minimum service obligation at a qualified practice site will result in penalties and fees pursuant to OAR 409-036-0120.

Required Attachments

1. A current copy of your curriculum vitae or resume detailing your employment history and education background.
2. A signed copy of your contract or memorandum of agreement (including all appendixes & attachments) to practice at a qualifying practice site
3. Statement(s) from your loan provider with detailed information on your educational loan(s)

Applicant Qualification:

All applicants must:

- Commit to practice in a qualifying practice site; **AND**
- Agree to serve Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area, as determined by the Authority up to a maximum of 50 percent with at least 25 percent of which is Medicaid; **AND**
- Be an eligible primary care provider type, providing outpatient care; **AND**
- Have an unrestricted license to practice in Oregon within provider's discipline; **AND**
- Not be currently participating in the National Health Services Corps (NHSC) Loan Repayment or Scholarship Program, Nursing Corps, State Loan Repayment Program (SLRP), or other service obligation.

Award Determination:

The following factors **may** be taken into consideration in the determination of awards:

- Providers who apply from a qualifying site located in a high scoring HPSA; **AND/OR**
- Providers who apply from a qualifying site located in a service area ranking below the median in the most recent Areas of Unmet Health Care Need Report; **AND/OR**
- Providers who apply from a qualifying site certified to meet the requirements of the National Health Service Corps; **AND/OR**
- Providers who practice at, or in affiliation with, a Patient Centered Primary Care Home; **AND/OR**
- Providers who meet specific needs identified by a community, including ethnicity, language spoken, specialty, or provider type; **AND/OR**
- Providers who apply from a qualifying site that is facilitating the integration of behavioral health and/or oral health services with primary care.

Application Checklist

- ☐ Completed and signed application
- ☐ Current educational loan documentation
- ☐ CV/Resume
- ☐ Copy of unrestricted license to practice in Oregon
- ☐ Copy of full signed employment agreement

Return the application form and all required attachments to:

OREGON OFFICE OF RURAL HEALTH

ruralworkforce@ohsu.edu *or* Fax: (503) 494-4798

Questions: (503) 494-4450 :: Toll Free: (800) 674-4376

HEALTHCARE PROVIDER INCENTIVE PROGRAM LOAN REPAYMENT APPLICATION

1. Biographical Information

Name: _____

SSN: _____

Date of Birth: _____

Address: _____

City: _____ State & Zip: _____

County: _____

Home Telephone: _____

Email Address: _____

How do you identify (optional)?
Please see the final page of this application for an optional demographics reporting form.

☐ I have completed the attached optional demographics reporting form

☐ I decline to complete the optional demographics reporting form

Are you bilingual? ☐ **Yes** ☐ **No**

Being fluent is defined as the ability to speak a language at a level that allows you to effectively communicate with a patient during a clinical encounter

If yes, please list which language(s) and level of fluency:

_____

_____

2. Profession & Education (please mark one, list license type and date licensed)

- ☐ Physician _____
- ☐ Physician Assistant _____
- ☐ Pharmacist _____
- ☐ Nurse Practitioner _____
- ☐ Dentist _____
- ☐ Expanded Practice Dental Hygienist _____
- ☐ Mental Health _____

Please indicate your specialty: _____

Please indicate your National Provider Identifier (NPI): _____

3. Participation in Other Incentive Programs & Employment Status

Have you received scholarships or loans with service obligations? ☐ **Yes** ☐ **No**

If yes, list the program(s) and describe the service obligation as well as dates of participation.

_____

_____

_____

4A. Employment

Are you currently working at the qualifying practice site at which you will serve? ☐ **Yes** ☐ **No**
If you answered "No" above, please proceed to 4B

Do you split your time between more than one practice site? ☐ **Yes** ☐ **No**

Please list the name(s) of your qualified practice(s) site and employment start date:

_____

_____

4B: If not currently working at the qualifying practice site at which you will serve, explain why and list the date you will be begin practice:

_____

_____

4C: Are you employed full time (at least 40hrs, with 32hrs direct patient care per week) or part time (at least 20hrs, with 16hrs direct patient care per week)? ☐ **Full-time** ☐ **Part-time**

5. Personal Background

List all postsecondary education.

College(s)	Degree/Certificate	Dates Attended

List the communities where you have lived, starting with your hometown.

City	State	From (Yr)	To (Yr)

Please keep your answers as brief as possible. If your responses will not fit in the provided space, please include them as an attachment when submitting your application

6. Essay Questions

Q1: What personal experiences have you had that have prepared you to work with underserved populations?

Q2: What has been your professional experience engaging with historically marginalized populations and/or rural communities

7. Certification

I hereby declare that the information contained in this application is true and correct to the best of my knowledge.

I authorize the holder(s) of my loan(s), the guarantor, or their agents to release information concerning my loan(s) to the Oregon Office of Rural Health for the purpose of verifying the amount of qualifying debt.

Full Name: _____

Signature: _____

Date: _____

Educational Debt Reporting Instructions

All spaces on this form must be completed even if the information appears on your lender statements. Any missing information will make the entire application incomplete and the application will not be reviewed.

Current lender statements must be dated within 30 days of submission and **MUST** include the **current balance, account number, your name, the loan's date of origination and/or school name**, **and original disbursement amount** for **each** loan reported. Online printouts are acceptable as long as they include all of the required information.

You must submit evidence of the educational debts listed below. **If your loans have been consolidated you must submit detailed documentation on the consolidation** (please see our FAQs)**.**

Only submit proof of debt for those loans obtained during the course of your graduate education (except for EPDHs) which led to your current license/certification as a qualified provider for this program.

The preferred file type when submitting all documentation related to your application is .PDF. ORH is able to accept .JPEG, .TIFF, or .PNG, files so long as they are attached to an email rather than imbedded. Files imbedded in emails are blocked by ORH's email firewall. **ORH is unable to accept files that can be altered (e.g. .doc & .TXT files), even if they are converted to a different file type before they are submitted.** (please see our FAQs)**.**

1. Lender Name:_____

   Lender Address (send payments to): _____

   City:_____ State:_____ Zip +4:_____

   Account Number:_____ Current Loan Balance: $_____

2. Lender Name:_____

   Lender Address (send payments to): _____

   City:_____ State:_____ Zip +4:_____

   Account Number:_____ Current Loan Balance: $_____

3. Lender Name:_____

   Lender Address (send payments to): _____

   City:_____ State:_____ Zip +4:_____

   Account Number:_____ Current Loan Balance: $_____

4. Lender Name:_____

   Lender Address (send payments to): _____

   City:_____ State:_____ Zip +4:_____

   Account Number:_____ Current Loan Balance: $_____